MEDICAL ETHICS II – STUDY GUIDE

* What are the ABCDE of medical ethics?
  + Assessment: gather info + communicate + assess interventions
  + Bioethical principles: autonomy + beneficence + nonmaleficence + justice + VALUES
  + Capacity
  + Decision
  + Evaluation: clinical outcome + ramifications

*Medical Errors: Prevention & Disclosure*

* Error of Execution?
  + Failure of a planned action to be completed
* Error of Planning?
  + Use of a wrong plan to achieve an aim
* Traditional Focus [vs] New Focus?
  + Deficiency in expertise and training [vs] organizations and systems
* **Serious Error?**
  + Error causing permanent injury or transient, but potentially life-threatening harm
* **Minor Error?**
  + Error causing harm that is neither permanent nor potentially life-threatening
* **Near Miss?**
  + Error that could have caused harm, but did not (by chance or by timely intervention)
* Rate of medical errors?
  + 18 per 100 ED pts + 40-60% rate of diagnostic error at autopsy
* Two types of failure: Active [vs] Latent Failure?
  + **Active Failure**: unsafe acts by those working at the point of production or those whose hands are on the controls when accidents occur 🡪 **sharp end errors** (more visible)
  + **Latent Failure**: consequences of decisions of designers/managers/policy makers who operate at a distance from the point of production 🡪 **blunt end errors** (systems errors)
  + Failure of Communication?
    - Faulty transmission and exchange of info + delays + assumptions + verbal orders
* What constitutes a Diagnosis Error? (3)
  + Unintentionally delayed Dx + wrong Dx + No Dx ever made
  + Systems problem + Sx support [vs] cognitive failure
  + **Taxonomy of diagnostic errors? (3)**
    - No-fault errors: unusual presentation of dz OR pt-related uncooperative/deceptive
    - System-related errors: technical failure, equipment issues, organizational flaws
    - Cognitive errors: faulty knowledge, data gathering, or synthesis
* Cognitive Biases:
  + **Anchoring?**
    - Tendency to be unduly persuaded by features encountered early in pt eval
  + **Confirmation bias?**
    - Attention paid disproportionately to observations that appear to confirm a hypothesis, rather than seeking evidence that might disprove it
  + **Prevalence bias?**
    - Tendency to overestimate prevalence of a dz if we have recently seen/read about a case
  + **Representative bias?**
    - Mistaken belief that circumstantial factors are representative of events we are anxious not to miss
  + **Framing Effect?**
    - Tendency to come to different decisions depending on how info is presented
  + **Availability heuristic?**
    - Tendency to judge likelihood by the ease with which examples spring to mind
* 3 patient safety models?
  + Culture of Blame: Retributive Justice + lex talionis
  + Culture of Safety: Restorative Justice encourages responsibility, reparations, & rehab
  + Just Culture: identifies & addresses systems issues that lead individuals to engage in unsafe behaviors, while maintaining accountability
  + 3 questions to ask when assessing medical error?
    - Was standard of care met?
    - Is doc willing to incorporate lessons learned into future practice?
    - Is doc committed to maintaining her relationship with the pt and participating in full disclosure of events?
* Nondisclosure?
  + Increased likelihood of litigation (12% 🡪 20%)
* Ohio HB 215 (2004)?
  + Prohibits use of any statement of sympathy offered by HC provider as evidence of admission of liability/civil action/related arbitration proceeding brought by an alleged victim of an unanticipated outcome of medical care
* How can we avoid cognitive error?
  + Metacognition: reflection of cognitive demands of situation + common pitfalls 🡪 regulation: use specific strategy to optimize CDM, avoid error
* 3 systemic factors increasing errors?
  + Lack of organization leadership for safety
  + Absence of suitable organizational culture
  + Failure to incorporate human factor of knowledge into policy design
* 3 predictors of medication errors in 3\* care ED?
  + Boarded status + # of meds ordered + nursing employment status at part time
* CPOE?
  + Computer physician order entry: may prevent some but facilitate other errors

*Infectious Disease*

*Medical Student Misbehavior, Mistreatment, and Mentoring*

* ­3 ex of misbehavior?
  + Cheating on exam + plagiarism + taking credit for work of another
* Medical student honor committee?
  + Student-run to address violations in a confidential manner
* Teaching ethics?
  + Observing/participating in unethical conduct may erode med-student’s codes of ethics, though 70% say that their personal code of ethics did not change over course of med school
* Paradox in teaching medical ethics?
  + Need to desensitize med students to human suffering/blood/guts in order to transform from layman to professional, yet we have a desire to produce compassionate practitioners
* Components of med student honor code?
  + Acknowledging that a physician is expected to adhere to the highest standards of honesty, integrity, and professionalism, I will strive to uphold these virtues and will neither cheat, deceive, or exploit others, nor tolerate those who do
* 7 components of med student mistreatment?
  + Humiliation, verbal abuse, institutional abuse, assignment of inappropriate task, physical abuse, sexual harassment, and racial discrimination
* How reduce med student distress? (5)
  + Create a nurturing environment
  + Identify + assist struggling students
  + Create an ombudsman program
  + Teach skills for stress management
  + Promote personal health
* 3 components of mentoring?
  + Nurturing to promote growth of mentee + mentor’s wisdom is acquired/modified as needed + supportive/protective

*Ethical Issues in Research*

* Nuremberg Code (1947)?
  + Voluntary consent of human subject is essential
* Willowbrook?
  + MR infected with hepatitis via feeding of stool extracts in order to get a bed
* Belmont Report?
  + National Research Act of 1974: created National Commission for Protection of Research Subjects in Behavioral and Biomedical Research
  + 3 keys to ethical of biomedical research?
    - Voluntary, Informed Consent = respect for persons
    - Assessment of Risks and Benefits = beneficence
    - Selective of subjects = justice: reasoning behind this study population, are they voluntary, are they free from coercion
* What makes a study population vulnerable?
  + Institutionalized + minorities + economically disadvantaged + very sick
  + 4 key vulnerable pop?
    - Children, students, prisoners, pregnant
* Conflict of Interest?
  + Undue use of position/power to influence a decision for personal gain
  + Financial conflict of interest?
    - Create perceived/actual tension between personal financial gain and adherence to values of honesty, accuracy, efficiency, and objectivity in science/medicine
  + Importance of disclosure of conflict of interest?
    - Public trust
  + Real vs Perceived COI?
    - Lead to biased decision making or perception of bias [vs] diminish trust even if conflict is not real
  + How protect integrity of researchers/institution?
    - Disclosure of anything of value to an individual or immediate family member = salary, consulting fees, honoraria, travel/lodging costs, debt forgiveness, **gifts > $50**, equity, etc.
  + Management of COIs?
    - Disclosure + divestment
  + Sunshine Provision of ACA?
    - Requires drug companies to disclose gifts **> $100**  to docs online: name, address, value, date, nature, product/device 🡺 **all info except national provider identifiers made available to public**
    - What is exempt?
      * Educational material + rebates/discounts + **payments < $10 until reaches $100** (then all must retroactively be disclosed) + Rx drug/device samples
* 4 consequences of scientific misconduct?
  + Violates public trust
  + Wastes time/money
  + Harm subjects/pts
  + Hinders search for truth
  + Definition of research misconduct?
    - Fabrication, falsification, or plagiarism in proposing, performing, or reviewing research, or in reporting research results

*Privacy and Confidentiality*

* What has contributed greatest to erosion of health care privacy?
  + Electronic records
* 5 reasons to protect confidentiality?
  + Ethical duty, legal duty, pt trust, protect pt relationships, prevent discrimination
  + 3 incidences where confidentiality should be breached?
    - Pt/3rd parties are in danger
    - Public reporting statues: contagious dz + abuse/domestic violence + judicial proceedings
* Legal mandates to protect privacy and confidentiality? (4)
  + 1974 Privacy Act: protects systems of federal records
  + HIPAA of 1996: Health Insurance Portability and Accountability Act 🡺 Indirect applicability: all organizations that exchange data with those directly covered under HIPAA thru Chain of Trust Agreements/contracts
  + Privacy Rule of 2001: standards for privacy of individually identifiable health info
    - Written patient consent required prior to disclosure of PHI, but emergency exceptions allowed
    - HPI: names, geography smaller than state, dates except year, age >89y, phone/fax numbers, email addresses, SSN, MRN, Health plan number, account numbers, certificate/license numbers, vehicular identifiers, device identifiers, URL/ IP addresses, biometric identifiers (finger print/voice print), full face photo/comparable image, any other unique ID/number/characteristic/code
    - 6 times can use PHI w/o pt authorization?
      * Waiver of consent approved by IRB
      * minimal risk to pt
      * privacy/welfare would not be affected
      * research can’t be practicably conducted w/o waiver
      * identifiers are protected from improper use
      * Identifiers are destroyed as early as possible.
    - Exceptions to disclose to parents for minors?
      * Mental health tx, pregnancy/contraceptives/STD, + minors subjected to abuse/neglect
    - Tarasoff v Regents of University of California?
      * Pt identified + threatened a 3rd party 🡪 psychologist notified security but not individual at risk 🡪 individual was murdered by pt
      * **Protective privilege ends where public peril begins**
  + Joint Commission Standards: policies/procedures to address confidentiality + rooms to give visual/auditory privacy
* Exceptions to confidentiality?
  + Criminal injury, impaired drivers, partner notification by public health, warnings by physicians to persons at risk, infectious dz, child/elder abuse, domestic violence
  + 3 types of reportable dz in OH?
    - Dz of major public health concern
    - Dz of public health concern needing timely response due to potential for epidemic spread
      * Anthrax, Botulism, Cholera, Diphtheria, Measles, Meningococcal dz, Plague, Rabies, Rubella, SARS, Smallpox, Tularemia, Viral Hemorrhagic Fever, Yellow Fever, Arboviral Dz, EEEV, WNV, Foodborne, H. flu, hantavirus, HUS, Legionnaires’ Dz, lymphogranuloma venereum, malaria, meningitis, mumps, pertussis, salmonellosis, shigellosis, s. aureus with resistance, syphilis, tetanus, TB, typhoid fever, waterborne
    - Dz of significant public health concern
* Consent issues of filming ED pts?
  + Recording with/without consent + Disseminating with/without consent
  + Preferable method for most purposes: re-enactment for commercial purposes [vs] acceptable for clinical/educational purposes as long as voluntary IC and pt confidentiality is maintained

*Informed Consent & Refusal of Care*

* Informed consent: 3 basic types?
  + **Express IC**: granting of authority to render tx
  + **Implied IC**: consent derived from conduct of the involved parties
  + **Consent implied in law:** emergency tx for pts unable to give consent
  + Autonomy?
    - Ability to make and carry out decisions about one’s life, because the pt knows his goals and values best
    - Freedom to choose between alternative methods of management based on expected results
  + Battery vs Negligence?
    - Battery: intentional, nonconsensual, offensive touching of the patient by the doc
    - Negligence: failure to satisfy a professional standard of care
      * 5 components of proving negligence in court?
        + Doc had duty to disclose 🡪 breached duty 🡪 pt was harmed 🡪 harm as result of undisclosed risk 🡪 pt would not have consented to tx had he known risks
  + 3 essential elements of informed consent?
    - Patient capacity + Information + Voluntariness
  + ED obstacles to IC? (4)
    - No prior relationship between doc/pt + time constraints + pts don’t choose doc + preservation of life/prevention of suffering as primary goals
* 4 elements to the process of refusal of medical care?
  + Determination of capacity + delivery of info + provision of appropriate medical care + documentation
  + What is decisional capacity?
    - Ability to make an authentic choice 🡪 Dynamic, situational, and task-specific
    - **4 components of decisional capacity?**
      * Ability to receive info 🡪 process, understand info 🡪 deliberate 🡪 make, articulate choices
  + Competence: legal [vs] medical definition?
    - Legal competence: able to manage his affairs
    - Medical competence: able to participate in decision making
  + 5 components of MMSE?
    - Orientation: Person, Place, Time
    - Registration: listen to 3 objects I have stated
    - Attention + Calculation: Serial 7s or spell world backwards
    - Recall: What were the 3 objects I stated?
    - Language: identify objects, repeat statement, follow 3 stage command, read and follow command, write a sentence, copy a design
  + Factors affecting pt capacity?
    - Mental capacity, delirium, pain, anxiety, confusion, depression, drugs (rx/illicit)
  + 5 exceptions to IC?
    - Emergencies: immediate intervention necessary to prevent death/serious harm (presumption that most pts would consent if given time and choice)
    - pt unable to consent: surrogate based on pt tx preferences (OR) substituted judgment based of pt preferences (OR) legal action to override surrogate decisions
    - pt waiver of consent
    - public health requirement
    - therapeutic privilege